PATIENT REGISTRATION

Thank you for choosing our office. We ask that you take a moment to complete the following form in its entirety. Thank you! All information will remain confidential and <u>is necessary for billing and insurance verification and to meet government regulations.</u>

Patient Name: _____ DOB: _____

SSN: _____ Sex: M F Marital Status: S M W D Sep

Address _____CITY_____ST_____ZIP_____

Contact numbers:

Home: _____ Cell: _____ (Carrier): _____ Work: _____

Responsible Party <u>Required</u> if under age 18:

Name: _____ SSN: _____ Relationship to patient:_____

*Government Requires the following questions be answered, <u>please **check one of the following**</u>:

***Race** __American Indian or Native American __Asian __ Black or African American

__ Native Hawaiian or other Pacific __ White __ Patient Declined to Answer

***Ethnicity:** ___Hispanic or Latino ___Not Hispanic or Latino ___Patient Declines to Answer

***Primary Language:** ___English ___Spanish ____Other (List):_____

Emergency Contact:

Name: _____ Number: _____ Relationship: _____

If you would like us to email a summary of today's visit, please provide:

Email: _____

What is your **preferred** method of communication? _____ **May we text you?** Yes No

May we leave a message with your emergency contact? ___Yes ___No

****Tricare Standard/Tricare Prime Patients*****

SPONSER NAME: _____SPONSER SSN: _____ DOB: _____

I, the undersigned do hereby assign directly to Mahan & Ridley Eye Associates all Medical and/or Vision benefits, if any, otherwise payable to me for services rendered. I understand that *<u>I am financially responsible for all charges not covered by insurance, as well as deductibles, co-pays, and co-insurance amounts</u>*. I hereby authorize the doctor to release all information necessary to secure payment from my insurance.

I, the undersigned, hereby authorize Mahan & Ridley Eye Associates, PLLC and any of its physicians and or staff to treat my medical conditions. The risk, benefits and alternatives will be explained to me at the time of service. **I have the right to question and/or refuse treatment at any time.** I hereby release Mahan & Ridley Eye Associates, PLLC and its physicians and/or staff from any liability. Refusing treatment, including keeping follow up appointments and taking medication as prescribed, may result in termination from the practice.

A ***refraction*** is a procedure to provide a prescription for eye glasses. It is generally ***not covered by medical insurance***. The ***cost is $30.00***. If this procedure is performed, I understand I may be asked to pay this amount at the time of service.

I consent to the use of disclosure of my protected health information by the providers at Mahan & Ridley Eye Associates, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Mahan & Ridley Eye Associates, PLLC. I understand that diagnosis or treatment of me by the providers at Mahan & Ridley Eye Associates, PLLC may be conditioned upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Mahan and Ridley Eye Associates, PLLC is not required to agree to the restrictions that I may request. However, if Mahan & Ridley Eye Associates agrees to a restriction that I request, the restriction is binding on Mahan & Ridley Eye Associates, PLLC and all providers in the practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that any of the providers or Mahan & Ridley Eye Associates, PLLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Mahan & Ridley Eye Associates, PLLC Notice of Privacy Practices prior to signing this document.

Mahan & Ridley Eye Associates Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Mahan & Ridley Eye Associates, PLLC. The Notice of Privacy Practices is provided in a booklet located in the reception area. This Notice of Privacy Practices also describes my rights ad Mahan and Ridley Eye Associates, PLLC duties with respect to my protected health information.

Mahan & Ridley Eye Associates, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Representative Description of Representative if applicable